

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
0 4 - 0 1 0

2. STATE
GEORGIA

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2004

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250 FACILITY

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 \$(567,373)
b. FFY 2005 \$((2,269,492)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-C, page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 4.19-C, page 1

10. SUBJECT OF AMENDMENT:
NURSING FACILITY SERVICES – PAYMENT FOR RESERVED BEDS

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME: MARK TRAIL

14. TITLE: CHIEF, MEDICAL ASSISTANCE PLANS

15. DATE SUBMITTED:

August 24, 2004

16. RETURN TO:

Department of Community Health
Medical Assistance Plans
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

FOR REGIONAL OFFICE USE ONLY

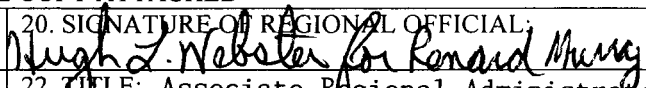
17. DATE RECEIVED:
August 26, 2004

18. DATE APPROVED:
October 12, 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2004

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:
Renard L. Murray, D.M.

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

PAYMENT FOR RESERVED BEDS

Regular state payment is permitted for reserving beds during a recipient's absence from an inpatient facility with the following limitations:

1. The patient's plan of care provides for absences, other than hospitalization.
2. Seven (7) days per hospitalization for Medicaid patients who are hospitalized during a stay in the nursing home.
3. Planned therapeutic home visits.
 - For nursing facility residents up to eight (8) days in any calendar year with no limit on the number of days per visit
 - For ICF-MR residents up to thirty (30) days per calendar year with no limit on the number of days per visit

Payments for reserved beds are made at 75% of the rate paid for days when a patient is onsite at a facility. Because payments for reserved beds are not subject to the nursing home provider fee, the payment rate for reserved beds excludes any compensation for the provider fee.